Problems of General Practice in Rural California

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SUMMARY

Medical care for rural populations is an important problem facing the medical profession nationally and locally. The mechanism for solution lies in the existing American Medical Association and California Medical Association committees on rural medical service and further development of "local health councils."

Additional emphasis on training of physicians for general practice is essential through medical school graduate and postgraduate periods.

The problem of providing additional adequately equipped and staffed hospitals must receive much consideration.

Recognizing that passiveness invites aggressive non-medical agencies to foster bureaucratic dictation inimical to the practice of medicine, the rural physician must act through medical and community organizations to correct weaknesses in the structure of medical practice.

INCREASING discussion by the lay press and rural organizations has focused critical attention upon medical care now being given the farm communities as units and as a whole. In response, the American Medical Association's Commission on Medical Service created the Committee on Rural Medical Service. Annual conferences sponsored by this committee have been held in Chicago since 1946. The purpose was to bring the various affected groups together with the American Medical Association committee for discussion of mutual problems. Individual state rural medical service committees have been established to work in conjunction with the parent American Medical Association committee on state and local levels.

In accordance with this plan, the first California Rural Health Conference was held in Sacramento, December 6, 1947. This conference brought together representatives of the California Medical Association, the State Legislature, the State Grange, the California Farm Bureau Federation, the Rural Health Association, the Wool Growers' Association, the dairy industry, the taxpayers' association, the Bureau of Agricultural Education, the Agricultural Council of California, the Public Health League, the Parent-Teachers Association, the clergy, the state nurses' association, the two dental associations in the state, the California State Department of Public Health, and laymen and physicians from the rural areas of the state.

The addresses and discussions were developed to bring out "the practical aspects of rural medical care." The remarkable point of the conference was the agreement of the majority of speakers that the solution of the various phases of the problem should be worked out by the communities themselves. The main request of the lay groups is for intelligent cooperative leadership and information. They look to their doctors for this aid. Unfortunately, the rural physicians themselves have insufficient information and their time is so limited that they have difficulty in taking upon themselves this added burden singlehandedly in each community.

A solution of the numerous problems probably lies in the organization of voluntary "local health councils." These local health councils, according to the American Medical Association plan,[6] are used instrumentally in furthering the spread of prepayment medical care plans. They may be expanded to meet any of the medical needs of the community, as they were developed in Alabama, North Carolina, West Virginia, Vermont and Virginia,[5] and are now being organized in Colorado,[4] and the country as a whole. They comprise representatives from all interested local groups. The activities and responsibilities are divided between committees as necessary. Development and guidance of such groups, if not the actual direction, is the immediate responsibility of the local physicians and the California Medical Association Committee on Rural Medical Service.

The most important problems confronting rural practice are: Increasing the number of younger adequately trained physicians; construction and maintenance of adequate hospital facilities with properly trained and supervised nurses, laboratory technicians, and other personnel; the continued improvement of office equipment, methods and assisting staff; prepayment medical and hospital service plan extension, evaluation and assistance at the local level.

The practicing physician's personal problems in office diagnosis and care of patients are urgent. More adequate, easily available clinical laboratories together with modern, efficient x-ray services are needed. Increased activity in the field of preventive medicine must be stressed.

It is clear that no one group, committee, society or, last—and least desirable—legislation, will solve these problems. Recognition of the various entities,

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analysis of the factors involved and utilization of all available agencies of organized medicine together with the assistance of interested community and state-wide organizations will serve both to advance the purposes and provide a common ground for fruitful effort.

TRAINING FOR GENERAL PRACTICE

The curricula of the medical schools are organized to cover the field of medical arts and sciences in four years. The basic or preclinical sciences and clinical sciences are increasingly emphasized to keep pace with the rapid advances in research. This tends to diminish the time available in the medical school and hospital graduate training period for consideration of the more philosophical aspects and the practical elements of the art and practice of medicine. The increased period of training and the financial burden have imposed economic and sociologic problems upon the young medical graduate sufficient to warrant immediate serious objective consideration.

Evaluation of the graduate and undergraduate training methods should take into consideration the problems of those members of the profession who have stretched or cut their academic ties but upon whose shoulders the major burden of practice rests. The judgment and opinions concerning these questions by this portion of the profession are not only worthy of consideration but necessary for the proper integration and development of medical educational principles and policies. Individually these physicians are mainly inarticulate. As members of medical organizations in their own communities, and in the state and the nation, they may exert their energy and ideas to effective measures.

Medical schools are not unaware of the problem of adequate training for physicians electing to engage in general practice, but it is only recently that a few have adapted a portion of their undergraduate and graduate programs specifically to the purpose of training relatively well grounded physicians for general practice. The University of Wisconsin Medical School preceptor plan, originated in 1927, has continued in operation. Each senior student spends three months with a preceptor located in a smaller center outside the medical school sphere. Here, guided and taught by an experienced member of the profession, he is exposed to the practical problems of actual diagnosis, care and treatment of individuals in their own environment. The fact that this program of practical undergraduate training has continued to function effectively for the past 21 years is high commendation of the medical profession, the individual preceptors and the University of Wisconsin Medical School for their cooperative understanding and energy in perpetuating the program of insuring adequately trained young men for the areas requiring them.

A number of the middle western medical schools are instituting two-year general internships with an optional third year residency to meet the demand for properly trained physicians for the rural areas. The University of Minnesota Medical School is in its second year of experience in this field, and the University of Michigan Medical School has a similar plan. Two years ago the University of Colorado instituted a broad program of undergraduate and graduate training for general practice which has changed the complexion of the graduating classes remarkably.[2] Prior to the change 90 per cent of the graduates were electing to enter specialties. Approximately 75 per cent of the 1947 class elected to enter general practice. Other measures are being developed to increase the number and quality of physicians for rural and general practice. The University of Illinois Medical School currently is to limit the enrollment of candidates from the metropolitan population to 50 per cent of the total enrollment, thus providing that one-half of the students come from rural areas and the smaller cities. Scholarship funds for students electing to practice in rural areas have been established by the Medical Society of the State of Illinois. Other states in the Middle West have established scholarship funds and loan funds for the same purposes.

Postgraduate education has been given a marked impetus since the war. Primarily the medical school and teaching hospital programs were designed for the returning veteran. The number of veterans interested in intramural postgraduate work is now diminishing. Many of the departments are now engaged in redesigning their courses to the needs of the men who have been and are in actual practice. There is a marked difference in the problems of the two types of physician. The veteran has an opportunity for a "breathing spell" and is partially subsidized for his period of study. This is not the case with the physician actively engaged in practice and well rooted. It may be necessary to devise special methods to provide adequate refresher courses and postgraduate training for these physicians.

HOSPITALIZATION FOR RURAL COMMUNITIES

Analysis of the financial provisions of the Hill-Burton Act, together with information in the preliminary hospital survey for California by the California State Department of Health Bureau of Hospitals,[3] indicates that the funds provided from both federal and state sources will cover only a small fraction of the cost of hospitals of the kind and size needed for rural communities. This, coupled with the obvious disadvantages of governmentally dominated and directed construction, emphasizes the importance of local initiative and direction in this field. Full financing within the community might well be a better and ultimately less expensive procedure.

Concomitant with the problem of providing hospitals is that of adequate nursing staffs. Training and abilities of nurses for rural hospitals must be general, with stress upon adaptability, initiative, and resourcefulness to adjust simplified measures and equipment to emergencies as they arise. In this regard the program of nurse training at the University of Minnesota hospital might be examined with profit. Some of the members of each class are

assigned or may elect a three-month period of training in small general hospitals before graduation.

RELATED CONSIDERATIONS

The supply of x-ray and clinical laboratory technicians must be greatly augmented. Small hospitals must find technicians capable in both fields if they are to survive the burden of overhead and operate self-sufficiently. Individuals trained to competence in both fields are not now generally available, nor is the duality of duty looked upon with favor by licensing bureaus or hospital authorities.

Organization of the medical staff of each hospital, with frequent meetings to discuss problems arising in practice, will greatly enhance the value of the hospital to the community and to the physicians themselves. Regular staff meetings, journal clubs and the added incentive derived from associations in the hospital are a spur to continuation and post-graduate study, and even to research. Increased and continued emphasis of preventive medical practices must be stressed. Early correct diagnosis and treatment of the patient must be repeatedly emphasized. The general practitioner must recognize that the over-all programs of the national, state and local committees of organizations such as those dealing with heart disease, cancer and arthritis, rely ultimately upon him to carry on the work of case finding, segregation and treatment to the point where special services are required.

Much in the fields of medico-economics and public relations that is of importance to medicine as a profession is neglected by the rural practitioner. In the past these factors were unconsciously dealt with by the individual physician. Complexities now require coordination of effort to counteract the forces in opposition. Increased thought, study and enterprise by the individual physician through his community, county and state organizations are needed.

Plans should be developed for adequate custodial care of the patient to supplant the antiquated relief homes, poor farms and rest homes now in operation. The county-operated infirmaries might well be supplanted by institutions operated in conjunction with community or local hospital district units to permit the care of self-respecting elderly people as such, in spite of personal financial difficulties. The problem of increased medical care and expense incidental to advancing years and reduced income should be worked out by the physicians, the community, the families and other responsible agencies, and not left to the vagaries of political expediency. This is said in an effort at objective analysis looking toward a program to correct obvious weaknesses and defects in rural medical practice, for a passive attitude by medicine in such matters will encourage aggressive non-medical agencies to foster further bureaucratic developments which will serve to limit the effectiveness of medical practice.

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Discussion by J. FRANK DOUGHTY, M.D., *Tracy*

The problems of rural medical service have been well presented in this paper. Few doctors graduate from medical schools today, trained to be a "complete doctor" such as is required for rural practice. Eighty per cent of the illnesses can be competently cared for by the general practitioner, and at much less expense to the patient. There is little indication that our medical schools, necessarily staffed by specialists, are aware of their responsibility in this regard.

Hospital facilities in rural areas would attract physicians and make for better quality medical care. The Hill-Burton Act is encouraging hospital construction in rural areas. In California, our State Department of Public Health was ready with the hospital survey, conducted by its Division of Hospital Surveys, ably captained by Dr. Philip K. Gilman. As a result, California will have more hospital beds. Many communities are financing their own hospitals in whole or in part.

There is a great future for the well trained doctor who is interested in the individual and the family, to render medical service in the rural areas.

The "complete doctor" treats the individual as well as the disease, and great are the satisfactions of such service in rural America.